Establishing Collaborations with Local Jails

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Table of Contents

Welcome and Introduction

Lynn Aronson

Hello everyone and welcome to today's PATH Teleconference. Our topic is establishing collaborations with local jails. My name is Lynn Aronson and I'm from Advocates for Human Potential, in Delmar, New York, and along with our colleagues at Policy Research Associates, we provide technical assistant for the PATH Program.

I will be today's moderator, and we are delighted to have with us today Henry J. Steadman, president of Policy Research Associates; John Fallon and Paul Mireles, from Thresholds, in Chicago, Illinois; and Kelly Williams from Suncoast Center for Community Mental Health in St. Petersburg, Florida. Welcome to you all.

Today we have people participating on this call from all over the country, including staff from PATH-funded agencies and representatives of the State and Federal government, including our project officer, Michael Hutner, and we welcome Michael to our call, as always.

We welcome you all and thank you in advance for your participation in the call. Our format today is a little different than any other that we've done so far. Instead of one question period at the end of the presentation, there will be opportunities for questions and answers after each of the major topic areas to be discussed by our presenters. Hank Steadman will do his presentation, and he will then bring up a topic; Kelly, Paul, or John will then react to that topic; and then we'll open it up for questions.

Now I would like to introduce our featured speakers. The first presenter is Hank Steadman, president and founder of Policy Research Associates in Delmar, New York. Previously, Dr. Steadman ran a nationally known research bureau for 17 years for the New York State Office of Mental Health. His work has resulted in eight books, over 130 journal articles in a wide range of professional journals, 20 chapters, and numerous reports.

Among Dr. Steadman's major current projects are the National GAINS Center for Persons with Co-occurring Disorders in the Justice System, the Violent Risk Assessment Software project from the National Institute of Mental Health Small Business Innovative Research Programs — and that's a mouthful, the John D. and Catherine T. MacArthur Foundation Prevalence of Mandated Community Treatment Study, the National Institute of Justice Mental Health Court Evaluation, and SAMHSA Technical Assistance and Policy Analysis Center for Jail Diversion. Dr. Steadman received his BA and MA in Sociology from Boston College and his PhD in Sociology at the University of North Carolina at Chapel Hill.

From Thresholds, a PATH-funded organization, we have John Fallon and Paul Mireles. John is the coordinator of Demonstration Projects at Thresholds and directs two specialized teams working to place people from Cook County Jail back into the community. Typical members have a history of 50 arrests, 20 psychiatric hospitalizations, and decades of homelessness. The success of this project has resulted in the American Psychiatric Association awarding it with the National 2001 Gold Achievement award for small community-based programs.

Hoping to duplicate this success in another setting, Thresholds and John have just started working on a grant to develop aftercare at two state prisons. John has 20-plus years of experience in the mental health field, which includes providing residential and outreach services to adolescents, children, persons who are homeless, as well as persons in correctional and healthcare settings.

Paul Mireles has worked in the mental health field since 1980. In 1993 he began serving with the Thresholds Bridge Mobile Assessment Unit, otherwise known as MAU, first as an outreach worker, and for the last eight years, as its program director. MAU services include two PATH- and HUD-funded outreach teams that cover the city of Chicago; two HUD- and City of Chicago Department of Human Services-funded Safe Haven residential sites; the Illinois Division of Mental Health- and CDA-funded sheltered linkage projects; and mobile linkage teams. MAU has collaborated with

the Thresholds Jail and Prison Program since its inception.

Last, but certainly not least, is Kelly Williams, a program manager for Suncoast Center for Community Mental Health, in St. Petersburg, Florida. Kelly has received her master's degree in social work from Western Michigan University and is a licensed clinical social worker in the state of Florida. Kelly has over 12 years of experience working with people diagnosed with a mental illness or co-occurring disorder, with people who are in crisis, and with the criminal justice system. For the past four years, Kelly has managed a focused outreach program for adults in jail.

Focused Outreach is a collaborative effort among three community mental health providers and one halfway house in Pinellas County, Florida. The county has a population of over 1 million people, and the jail houses 3,500 inmates, approximately 16 percent of whom have mental health issues. The Focused Outreach program began with a budget of $166,000 four years ago and has grown to a budget of just under $1 million at the present time. The program serves about 500 individuals per year.

I would now like to turn the presentation over to Hank Steadman. Thank you.

PATH Programs and Local Jails

Henry Steadman

Thank you, Lynn, and welcome everybody. Now that we've gotten through all the preliminaries, hopefully we'll throw out some ideas that will be of interest to you, some ideas that may facilitate the work that you're doing. We'll be anxious to see how this format works out in terms of hearing from everybody on the call and not just the introduced speakers here.

First I'll set the context. Some of you are intimately familiar with the jail and probably have had a lot of contact. Some of you may be less familiar. To me, in thinking about who's on the call and what the PATH Program is, why would you focus on the jail? Why would that be an issue in any U.S. community? With approximately 3,500 jails in the United States, what's their role in providing services for persons who are homeless, particularly persons who are homeless and mentally ill? The best estimates are that there's between 12 and 13 million bookings per year into U.S. jails.

I think that the best number out there, in terms of what is the rate of serious mental illness, in terms of active symptomatology at the time people are booked into the jail, is approximately 8 percent. Now that's a duplicated count, so it's not a million different people, but it's a million bookings per year in U.S. jails of people at the moment they are booked into the jail, have symptoms that are similar to people who are inpatients in acute psychiatric facilities. This is a high-volume, high-need group. Who are these people, what do they look like? I think there are four features that just jump out at you when you look at the descriptive profiles of who these people are. The first thing is, to no surprise, they're poor. That's who gets into U.S. jails and stays there.

The other feature is repeated cycles of bouncing from the jail to community-based mental health services, to substance abuse services and just continuing in any given year to just cycle through. They end up getting arrested, they come out of jail, they're on the streets, and they're in shelters. They get some sort of mental health interventions that don't work because they've got co-occurring disorders and the programs are not integrated treatment programs. They may get residential substance abuse treatment, they fail at that, they get rearrested, and it's just repeated cycles. Those are the people that we're talking about; those are the people that the PATH Program is looking at. I think this is a shared population, which is why I think it's very appropriate for this teleconference.

There's a conceptual framework that we at the GAINS Center and at the TAPA Center have come up with that on other features of the community care system or the social welfare system or the mental health treatment system. A term that I heard years ago that never really got much currency, but which I always have felt is a really apropos definition, almost, of the U.S. jail, is from a psychologist down in Tuscaloosa, Alabama. Stan Brodsky was the person, and he

called the jail a public health outpost. That's a really dynamic concept and very accurate. A jail is a place where people get processed and people are churned; there are just high levels of activity.

A Jail as a Public Health Outpost

In the social work literature, there's a difference between people-changing organizations and people-processing organizations. Jails are people-processing organizations; you churn people. Thinking about this as a public health outpost, one of the models that we've come up with, working with Patty Griffin, a consultant in Philadelphia, and Mike Munitz, a psychiatrist in Akron, is the Strategic Intercept Model.

Think of the jail as a place where, starting with law enforcement as an initial intercept point; then there's booking into the jail, the front door of the jail as the second point; and then from the booking people go to the courts, which is another intercept point; and then they leave the jail. Some may leave within 24 to 48 hours if they make bail or they may have to stay awaiting a court date or they may stay for 6 to 9 months while they're awaiting a court date and a disposition and then getting time served, then ultimately the last intercept point is when they're back on the street and they're getting community correction supervision and community-based services.

I like to think of the front door of the jail where we're talking about diversion activities. How do we prevent people, once they show up at the jail, from staying in jail, only because they're mentally ill and often because they're homeless? How can we do something to prevent them having to stay in jail, only because they're mentally ill, where they otherwise would be eligible for bond? Then at the back door we talk about reentry. In the PATH programs, there's really an opportunity for thinking about the strategic intercept of keeping people or finding people on this trip through the system. What are we going to do that's different?

U.S. communities that have effectively coordinated integrated programming with criminal justice, mental health, and substance abuse, have really done so because they've changed the definition of jail to a community institution. It's not a separate world where the perimeter security isolates the jail from everything outside it.

The jail health services, for example, see the jail as a point where people pass through, particularly poor people. Sometimes they're in the jail, sometimes they're in a shelter, sometimes they're on the street, sometimes they're in residential facilities of some type, but they pass through the jail. So this is a place where we can do something; it's a public health outpost.

That's the model, and it's consistent with the whole emphasis in the PATH Program of doing outreach. The irony is, when you think about the operation of a jail, one of the terms that has been coined in terms of a better linkage between the jail as a community-based institution and community-based services is "in-reach" into the jail, which is the mirror image of PATH outreach in that the focal point of the outreach is the jail.

Most American communities have failed at that. There are successes out there, and some of the successes are the people that run this call today. It's something to really strive for in terms of developing this strategic intercept mindset and looking at the jail as a public health outpost. There's a lot of opportunity, even in this time of restricted resources. But PATH resources and creativity provide a lot of opportunity that maybe five years ago wasn't there.

Engaging Jail Authorities

The first question, to me, an early question, is if you approach the jail, the jail administrator says, "How can you make my job easier? Why should I work with you?"

Suncoast and Thresholds have come up with some interesting answers to that question. I'll turn it over at this point to Kelly, initially, and then she'll pass the

baton to John and Paul to talk about when they first approached the jail and got that question. How did they respond, and then what do they do after they've responded? Kelly?

Kelly Williams

Thanks, Hank. Well that's a good question, and that is, of course, exactly what we started with when we were first tossing around the idea of starting a jail diversion program, because you can't really have much of a program if you can't go in the jail.

So when we did speak with the jail administrator, the question that he asked is, "Why should I work with you?" The response that he was given was, "We want to work with your most difficult inmates." Mentally ill people do not make good inmates. They get in fights, they are expensive — if you compare them next to regular inmates who don't have mental illness — and they typically have a higher rate of physical health problems.

As everybody knows, medications are extremely, extremely expensive. So it's really not a difficult discussion with your jail administrator to say, "Well let us try to reduce the influx of these people who are costing you a lot of money and are really difficult to treat." I'll turn it over to John and Paul now to hear what they have to say.

John Fallon

I echo what she says, though it's different in Chicago. In Chicago we're an awfully large jail, actually. We have about 100,000 people that are at Cook County jail and 10,000 on any given day.

I think the important thing is to follow the money. What PATH programs can offer and our programs can offer is some free services and some free entry into the mental health system. It's a different system. For the jail, the most problematic people are those that have committed the most serious crimes, which actually are less recidivistic crimes. Instead we're offering to work with those people who, just as Kelly explained, are difficult in another way.

For a jail, they're the ones who are the greatest liability. Perhaps we can cause these people not to come back. That's important to every sheriff.

As far as our entry into the jail, we did it through the county hospital. We were fortunate to already have good psychiatric services at Cook County Hospital, and they were interested, now, in accessing the beds and the services, but there wasn't any funding.

So Thresholds offered to provide two cases workers to go in, and the jail agreed that they would give us access to would work with their most difficult people.

We saved them a lot of money. We may not have saved the jail as much money as we saved the taxpayer, because, in fact, these are people that are in and out of state hospitals and the jail a lot, and in the court system, and who clogged up those systems.

What we discovered is that with 30 people, if you compared the amount of time that they spent in jail and the hospital before and the cost of that to the cost afterwards, the savings was about a million dollars. That may not be directly attributable, but the fact is, it's helpful to keep these people out of jail who don't necessarily belong there. Those are all the things that were persuasive in order to work with them.

Discussion

Lynn Aronson

Okay, we're now going to open up for the first question period.

Q. One of our callers is asking what are the greatest challenges that you faced in starting an effective jail diversion program? Kelly and Paul, these are directed to you.

Kelly Williams

In Pinellas County we do not have a central receiving system, so we do not have any one place where you can get information about a person with mental illness. They can access multiple services in the community, and you don't have any idea of what

services a person is involved in, all at the same time, unless of course you're working with the client.

We had to resolve some pre-existing issues with our jails on sharing information. Our jail felt that when a client who was a known mental health consumer in the community was booked into the jail, they would contact these different agencies to try to get their medication information so that they could continue the treatment while the person was in jail. They didn't get a good response, and different agencies responded in different ways. Some agencies refused to give them any information at all, especially after HIPAA. So before I could even get them to work with this new program that we were starting, I wrote some general policies and procedures for the major mental health providers that we would all follow. Again, our program is a collaborative program, so I was working with several mental health centers and changing how they dealt with the jail. John or Paul, do you have anything?

John Fallon

Actually the two largest problems that we have are gaining access to the jail and communicating with the jail. Then to understand that the court actually controls the release, and the sheriff releases people in a manner that generally results in late night discharges.

Since we've been in this project, the jail has started to release people a little bit earlier, but it's still night releases, and mental health agencies are generally are around during the day. So those are the two difficulties, and we've had to solve that by attending court.

As far as the access, we have a cooperative agreement with the Office of Mental Health to be able to share information with the jail. But that required legislative approval. In the short-term, it simply was beginning to have relationships develop between the jail hospital staff and the community so that they could get to know each other individually and learn those things. So that's been an education process on both sides.

Henry Steadman

One of the things that John mentioned is the unpredictable flow of detainees at the jail, particularly in a large metropolitan jail and the mega jail that Cook County represents in Chicago. Certainly even Pinellas County, where Kelly is, is a large enough jail that you're not just dealing with the jail, as John said, you're dealing with the court. The court is really the funnel in and out of the jail.

I mean the police may bring them to the "sally port," but once they're booked into the jail they're at the mercy of court hearings and transportation to and from the court. Or it may be a video booking or video releases or video bail, depending on the arrangements that individual jails have with the courts, but the courts actually dictate when people leave.

As a community-based mental health provider, when we're trying to put a diversion treatment plan together or trying to do a transition reentry plan, there's a lot of coordination that's needed, with, for example, medication continuity.

Obviously, housing is a huge issue. You may have all kinds of family issues, particularly if you have women. You've got issues in terms of who has custody of the kids and where they are. You've got health. Then in putting an acceptable package together, if you're going to divert the person, you've got to convince the court and the prosecutor that you've got an alternative to either dispose of the charges or put the person on bail if they adhere to the terms and conditions of treatment.

If you're doing a reentry, because a person is completing their case and they're going to be put on probation when they go to court, you're putting together a package so there's a lot of coordination. At the same time, all of a sudden you've got three days before you've got the opening, the slot that you need to get them in that residence, and their court date gets moved up, and all of a sudden they're out the door, and it fell apart because it wasn't on the timetable of the coordinating group.

One of the real challenges is this fast turnaround, this relatively unpredictable flow that the mental health staff doesn't have any control over. And you're doing work that requires not just unilateral decision-making, but collaborative decision-making, in terms of how you can actually manage that.

Lynn Aronson

Thank you, Hank. At this time there are no further questions. Kelly, I'll turn it back to you if you want to react to what Hank just talked about.

Kelly Williams

Yes, it can be overwhelming when you get in there and start working with people and realize who all these different people are that you have to communicate with and how incredibly time consuming it is. It's hard to get, for example, a funding source to understand that you need to have flexibility in your funding to have a person sitting in an office, on the phone all day, coordinating all these services.

The Strategic Intercept Model

Hank, I'm going to go back to your model that you talked about, the strategic intercept model. You pointed out that there's basically four different areas that you can focus on: the police, which would be pre-booking; but then the booking, right when a person is coming in; the court phase; and then the discharge phase. To try to manage some of the instability with that, we chose one area to work with. We put our service around getting the person in immediately for medicine once they were discharged, but we do not promise housing upon discharge. It's just impossible.

You can't get a person into a housing place when you don't even know when they're going to be available to be interviewed by the housing provider. So Focused Outreach does not offer housing per se. We do, once the person is out, work with local shelters. The person goes to the shelter and then we link them up with the housing.

Then in order to continue the mental health treatment, we basically created a walk-in mental health service. So regardless of what time of day or night the person was discharged from the jail, they knew that at 8 o'clock that next day, they could go to a specific location in the community and get their mental health services. So that was the two ways that we dealt with that fast turnaround and unpredictable flow of detainees. John and Paul?

Paul Mireles

I wanted to comment on Hank's question about where it all falls apart. In our mobile assessment unit, as a traditional outreach and engagement service provider, we offer interventions to the individual needs of each person. So as the PATH-eligible individuals begin to trust the outreach workers and disclose that they've recently been released from jail, the staff assists the client by transporting them to court appearances. But if the staff is unable to locate a client and suspects that they've been arrested, the outreach workers call the social worker, who has quite a caseload at Cook County Jail.

If a PATH client is in the general population, the social worker attempts to arrange a transfer to the mental health section. Then, Thresholds staff will also notify Thresholds Jail and Prison Program to provide onsite transition planning at Cook County Jail. So these are the collaborative efforts between our PATH-funded Thresholds Mobile Assessment Unit and the Thresholds Jail and Prison Program.

John Fallon

If we find them in jail, we then follow along with them to court. We treat every court day as a chance to be prepared for a release. So we have an ACT team on call and a linkage team, and we have people there who attend court, who then call someone if the court is going to release a person, because we also work with people if they're innocent. We do intend to provide housing, because that first 48 hours is absolutely critical, so we always feel that a person needs to be housed immediately, and so that's a goal of ours. But again, we are focused on the most difficult folks.

Whenever possible, we arrange to have them released to us. If the person is on any kind of probation, we ask the court to release only to us. We have an agreement with the jail, if the court will agree to release only to us, to then fax that to the jail along with what we call the coordinated release form, which lists the date that Thresholds will come and pick them up and the time. The jail then arranges the release rather than have us wait for six hours. Cook County Jail has been working very hard on getting this to work.

But in addition to that, we always have a doctor on call and are able to see one of our members within 24 hours. Our psychiatrists are great in that way. In addition to that, we've arranged with several hotels where we can call that day and place someone there in emergency housing. We give them the name and sometimes we'll even give them a pass code, if necessary, so that they know who the person is, because they're going to be coming in without IDs. Then we arrange within 24 hours to help them get clothing and start the benefits process. So we're always focused on meds, housing, and starting the benefits process as soon as possible.

Discussion

Lynn Aronson

Q. We do have a couple of questions. One of the questions, and it's probably to either Kelly or John or Paul: Did you get support from your State's attorney?

John Fallon

We do now have a mental health court here in Cook County that's just beginning, so we'll have three courts that work with us.

Lynn Aronson

Q. Kelly, how about you?

Kelly Williams

Yes, we did get support from the State's attorney. That was probably two years into the program, so it didn't happen right away. It took some time to really build up that relationship and let people see what we were doing in the community in order for them to buy into the idea that, hey, this isn't so bad; it might work; and it does actually seem to help people.

What that means is that the State's attorney has, I believe, 32 days to pick up the charges. Once the charges are filed, the law enforcement officer drops the person off at jail and turns in a piece of paper with whatever this person was charged with. The State's attorney can decide to pick that up and continue that legal process or not. So there are some petty charges, misuse of a shopping cart, for example, that are obviously not directed at another person; nobody has been hurt; the person is getting this charge repeatedly, over and over again. If the State's attorney will agree to not pick up that charge, then the client doesn't have to go through that court process again, and we can just link them right into mental health treatment services.

Ensuring Continuity

Lynn Aronson

Q. This question is, what plans are in effect to see that when a person is released they have a continuity of services? Often there is a release from jail and the transitional case management is virtually nonexistent. Also, what is done to assist an individual in receiving housing? Has a transitional housing program been considered? I will start with Paul or John on this one, and then we'll come back to Kelly.

John Fallon

In Cook County Jail, we have small individual programs that do house people. The jail is increasingly recognizing this as a public safety/public health problem, but there's certainly not the capacity to deal with everyone that comes out. Statutorily, the jail is responsible for holding people for the duration of time of the court case and not necessarily responsible for a person being housed or services being provided.

That's simply how the system is, and we do the best that we can, and we help who we can in our PATH provider, and we provide about 1,000 beds for housing. But those are generally full, and the mental health system is already at capacity. That remains a problem.

Part of what PATH providers can do is continue to point out that there's a million people in jail and 600,000 that are going to be getting out this year in prisons. We need to build the capacity for our failures and increase the services, and that's not happening in the current funding environment.

Paul Mireles

We do have the Shelter Linkage Project. It's a large overnight shelter in Chicago, right around the corner from Cook County Jail. We do have folks that are using the shelter, and we have a special mobile assessment unit worker stationed in the shelter Monday through Friday from 8 a.m. to 4 p.m., and their charge is to try to engage any individuals who are PATH eligible. Services are specialist case management programs and maybe other local community mental health providers. So we try to establish some continuity once someone has left the jail. We try to, again, identify when they may have some court appearances.

Kelly Williams

Focused Outreach is different in that we have both the in-reach workers in the jail and the outreach workers in the community and the treatment component. We offer individual and group therapy, and all services are co-occurring. So they're concurrently providing mental health and substance abuse treatment. Pretty much we provide the mental health services for the client once they come out. That enables us to offer good continuity of care by engaging the client immediately and then linking them with community health care and housing.

The Focused Outreach Program does have a subcontract with a halfway house; we buy beds from them for the clients to be able to stay there. Again, that's a very small number of people because there are just not enough resources available for everyone who's coming out of jail. We do all really need to advocate increasing those resources because the number one problem in reducing recidivism is helping people get stable in the community when they're first discharged, so that they don't repeat that cycle.

So the treatment services of the Focused Outreach Program are designed to be short-term. They're typically six to nine months long so that we can provide the person the treatment services while we are linking them to permanent services in the community.

Psychiatric Medication

Lynn Aronson

Q. I have one more question Kelly. With limited community psychiatric services, how did you handle follow-ups for psychiatric medication upon release from the jail? Are prescriptions written upon release and, if so, for how long?

Kelly Williams

That's a really good question, and I know that there are a lot of communities that have limited psychiatric services. That was one of the big problems in Pinellas County. At first this program was funded through a legislative budget request to the state of Florida, and in that request we included money for psychotropic drugs. So basically the program had its own supply of medications, and then we also included the psychiatric services in our funding proposal for the program.

So a lot of time when you're putting together a program, you put together all the treatment services and support services but you forget about the medical services, which are very, very expensive and in short supply. So luckily, we knew the number one thing to help somebody not go back into jail is to help keep them on their medicine so that they are aware of what they're doing and don't fall back into patterns.

Basically we created our own medical services and added those in with what we already offer, which are limited services that people have to wait a long time for, but that's how we're able to create that walk-in type of setting that I talked about, where we have somebody available to see the client and then are able

to get them in to see a nurse or a psychiatrist in a timely manner, which is what they need.

Of course, they usually don't have a funding source to pay for their medicine. Anyone who is incarcerated for more than 30 days — if they had Medicaid, they've lost it at that point. Of course, Medicare doesn't have prescription coverage. So usually if they had benefits before they went in, they do not have them when they're coming out. So you have to be prepared for that and have some funds to provide the medicine for that 30- to 60-day period while you're helping the client reapply for the benefits.

Lynn Aronson

Thank you, Kelly. I'm going to turn it back to Hank now to go on with the next segment.

Henry Steadman

Okay, let me just have one follow-up note. A few years ago in Lucas County, Ohio, the community mental health provider who did in-reach into the jail used their prescription power before the person left the jail so that they had a 30-day supply of meds when they left, on the prescription that they carried out of the jail with them. But Kelly's situation and Lucas County's were rare. It's a real difficult issue out there.

Understanding Jails and Corrections

Often when mental health professionals get together and talk about these dilemmas at the interface of the criminal justice and mental health system, we put a lot of knocks on the criminal justice system and how their values many not be consonant with ours and how the public safety orientation gets in the way of the best interest of the individual and trying to get them in an integrated treatment system.

But one of the impediments to effective collaborations that we have seen periodically around the country is that many mental health case managers, particularly who tend to be relatively young and not highly compensated, do not have much education or experience working with jails. They have a lack of understanding about the jail culture and the values of the jail.

As mental health professionals, we are visitors in their house. First and foremost, jails need to be secure. Often when mental health professionals talk about cross training, they do it from the standpoint of training the criminal justice professionals, the corrections staff, to understand mental illness, and they don't see themselves in need of training.

I think one of the things that you see in communities where there has been successful collaboration to break the cycles, is that the mental health staff has learned what those cultures and values are and understands that they're trying to accomplish the same thing. I know that down in Pinellas County and in Cook County there's really been a lot of development along these lines.

It's worth talking about a bit for other communities to have the most successful collaborations. Maybe we'll start with Kelly and then go to John and Paul.

Kelly Williams

Thanks, Hank. Yes, that's usually a big shocker for your staff the first couple of times they go in there and then come out and say, "Well the clients are floridly psychotic, and they don't seem to be doing anything about it in the jail."

Good advice for anyone who is trying to establish a relationship with the jail is to seek out the trainings that the detention deputies have to take, specifically the public safety trainings, and they may even have some trainings about dealing with difficult inmates or with mentally ill inmates. Ask the jail if you can send one of your staff people to those trainings so that they can see how these people are being taught.

The first thing that they're going to notice is that it's way different than any kind of mental health training your staff has ever had. The other important thing is to make sure that your staff, your mental health staff, understands that the jail isn't a treatment center. Their role in the community is to detain inmates while they are being prosecuted for the crimes that they have

committed. It's a holding pen for people who have not lived according to the law.

So really the jail is not, at least in Florida, required to offer any treatment that isn't essential for the person's survival. There are some people who feel that mental health treatment is not essential for a person to survive. So that's really a big issue, and you want to know your jail's perception of how much treatment is necessary.

Every jail, I suppose, probably has a thing called contraband trainings that is usually offered to civilians, people like us, who are going in and being a visitor inside a jail. That is to let people know how to behave when you're going in, what you can bring in with you, and how to behave while you're inside. Find out when that training is offered and request that your people be included.

Another thing to recognize is that the jail is a paramilitary type of structure. So basically the deputies are accustomed to doing what they're told. So find someone, maybe a shift commander, who is interested in allowing your people to come in and do some mental health training with the deputies. When the deputies are told that they have to attend the training, they attend the training. So a good way to get your mental health training piece in there is to go a little bit higher up on the ladder there and go for supervisors, shift commanders, people a little bit higher up and who will tell their deputies that they have to attend the training, and they'll show up for that.

Lynn Aronson

Thank you, Kelly. Paul or John?

John Fallon

I'd like to reiterate that we are guests when we go in a jail. I remind listeners that people get killed in jails. Not just from suicide, which is what we often hear about, but officers get killed. It can be a dangerous place, not necessarily from the folks that we might work with, but they don't know and you never know when someone can get hurt.

People can be creative in the jail. To give an example, our business card got loose in the jail on one of the units where we weren't going to work with people, and we got lots of calls from public defenders and everyone else who had inmates announce that Thresholds had accepted them into their program and that they should be eligible for plea bargains. So you just have to be careful. Almost anything you can do in a jail situation is often — information moves very quickly.

Working with Housing Partners

The other thing that was alluded to was the other allies that we have. For PATH providers the big ally that you have, of course, is people who are interested in expanding housing. So find people who are interested in breaking down barriers against people with felonies, against people with criminal histories, such as unnecessary background checks for long overdue offenses. One of the places to work with is often continuity-of-care agreements. Each community who wants to get HUD funding has to be a part of a continuity-of-care group.

In Chicago we have a very large one with lots and lots of providers, and originally in the application they didn't follow the CHA guidelines and didn't have ex-offenders in the original mission. Well, now we not only have them included, but we're a primary part of the discharge planning and we're working closely with both the prisons and the jails, and most recently we've begun to work on a regional level, meaning that there are about seven or eight continuity-of-care groups working together.

There are also common interests. We seem to have found that we can't continue to build prisons over and over again, that we can't build our way out of these problems, and so there are reentry committees. The complicating fact about working with jails is that there's often State funding, county funding, city funding, and Federal funding, and all of these criminal justice things are interrelated in that releasing more people from the jail involves city funds with police, or county for the jail, or State mental health in prisons. So building reentry committees, starting with your city and then building them to

county and State, those are all places for PATH providers to be at the table to advocate for increased housing.

The last is in terms of the training that one does. Teach the sheriff and then other mental health providers to help to reduce the stigma of this group, because, particularly with the mentally ill, these are the people who used to be in state hospitals, and they're the same people we worked with successfully before. Concentrate on the doable. Don't concentrate on the huge heater cases; instead look to the smaller cases, where there are people who've been in 100 times for small little shopping-cart type crimes. Work on those and build those successes and plant positive stories.

That can't be emphasized enough, to plant positive stories with politicians, where they see the successes. Then inevitably something may go wrong. You're working with a group where there could perhaps be dangerous consequences, so you want to be able to offset that publicity.

Confidentiality

Lynn Aronson

Q. This question has to do with how can PATH-funded program staff inquire about or access past incarceration history without compromising the clinical relationship? Kelly, let's start with you.

Kelly Williams

Well, I think that the answer to that question may differ from state to state. In Florida it differs from county to county. Our systems are not integrated across the whole state. So the local county jail information is a matter of public record. You maybe can go to your county administration office and ask them how to access that information. Then for the clinician, since it is a matter of public record, you of course would ask the client, but a lot of times they are not sure what their charges are. Sometimes they don't want you to know what their charges are. There's a whole variety of things that go along with that.

But a lot of things happen in court, and sometimes the clients don't really understand what has happened to them. So I think it's a good thing for the clinician to try to assist the client, and try to look up their records and determine whether or not they're on probation, and help the client to understand. What does that mean? Why do you have to go see the probation officer? Lots and lots and lots of seriously mentally ill adults are re-incarcerated because they have violated probation, because they do not understand what is expected of them.

So I would suggest: Go to your county office and ask them how to access the county records. At Suncoast Center, we pay a monthly service fee in order to have access to that, and it is available right over the Internet. Thanks.

Lynn Aronson

Thanks, Kelly. John or Paul, in Chicago?

John Fallon

In terms of how you access the records, same thing. Actually, if you want to check the prison history, which we often do, for the folks who are in the jail project, you can usually go your Department of Corrections Web site. They actually will list who is on parole, and you may even get nice pictures of them.

As far as police records, you can't get them directly. But again, we are able to access court records. You can get a rough equivalent of what a person was charged with if you just simply look at what court cases they had through your local county clerk. That's something that we can check rather quickly in the clerk's office, on the computer, without any special access. Usually if you've got 100 arrests, you likely have 80 or 90 of those are actual cases.

For us, a person enters the relationship with us through the prisons or jails, and so we knew it from the beginning. It's part of our clinical work that we're doing with the person. We have an agreement that we will continue to look at their past and future cases, at their outstanding warrants, and to deal with their probation officer.

We've also told them ahead of time that we've got the agreement that they don't want to be in jail, they don't want to be in the hospital, and so they've agreed to work with us. If they're agreeing to work with us, that means that they're also agreeing that they need to do some reporting if we feel that's necessary in order to help them stay out of jail and stay out of the hospital. That's well established in our relationship.

Now that's quite different than our mobile team, which has an engagement philosophy. I'll let Paul speak to that.

Paul Mireles

Just to add to what Kelly was saying, in terms of working with probation officers, we actually have the relationship with a probation officer who is very motivated to help the folks that are being released from Cook County jail and that go to Pacific Garden Mission, which is probably the largest overnight shelter in Chicago. So we're able to receive calls and referrals from him, and to date we've had maybe 50-plus referrals, but unfortunately, maybe, like a 20 percent retention rate in terms of helping people down the road.

So we have tried to work with probation in order to have people understand what their charges are and when their court appointments may be, and we provide transportation to those appointments.

Lynn Aronson

Thank you. Are there any other questions?

Coordinating Release and Other Court Dates

Caller

Q. Thank you. Good afternoon. I'm a corrections case manager for people with serious and persistent mental illnesses in the Mercer Country Correctional Facility in Trenton, New Jersey. My problem is release planning. In county jails, the release dates are never static, so it's very difficult to do release planning with appointment dates and things of that nature. How do you handle that or do you have the same problem?

John Fallon

There is no real easy way. We have a caseload of about a dozen that we actually work with at any given time in the jail, and we prepare every week. If they go to court every week, we prepare every week for all 12 of those to perhaps be released that day.

There's usually a pattern with each of the jails. Generally just before holidays, they release a whole lot of people, so that they're not going to be there for Christmas or they'll extend it longer. There are other sorts of patterns. But generally there's not much of a pattern to it and it is difficult. It's the reason, as Kelly said, you have to have extra money there and you have to have extra capacity waiting there, because there's going to be a lot of time that you can't productively use.

Lynn Aronson

Thank you. Okay, I'm going to turn it back to Hank now. I think we have one more segment.

Policies and Procedures

Henry Steadman

Yes, one other area that we thought might be worth talking about is, how do you get MOUs, memorandums of understanding, or policies and procedures written down or concretized. You see this in jails where some people are really working hard and are well intentioned. They're skilled and they come up with an arrangement that works for everybody, and then one of them gets a promotion and leaves. Then the arrangement, the understanding they have for sharing information, or accessing "rap" sheets, or notifying someone with enough lead time that the prisoner doesn't get dumped out at 3 a.m. in the morning with no residence and no medication, it falls apart. It was an understanding that the two people had, and it didn't get written down. What happens in the two programs that we've got

here, from Cook County and from Pinellas County, in terms of how you have handled that? Have you actually developed MOUs in any of these areas? Do you, in fact, think it's important to do that? What advice might you give to the other people on the call?

Kelly Williams

Sure, thanks, Hank. Developing the memorandum of understanding is really, really important. I would even say to the caller who just asked that question that a solution to his problem may be taking the steps necessary to develop that memorandum of understanding with the different community mental health centers that he's trying to link the inmates to.

But that's the first step, because then administration is aware of the issue. You need to have administration if you're talking about two or three different systems coming together and working together. The administration of those systems needs to all be onboard.

I do have a memorandum of understanding with as many agencies as I could get, and the jail, and the court system. Because again, it's important to recognize that your jail and your court system are two different systems.

Then in our third year of the program we developed an administrative order. We did that by working with the judges and explaining to them that we're trying to identify people in the jail in need of mental health services and get them out of jail and link them with the mental health services.

What we found is that there are some people, some people, a small number of people compared to the volume of people that we're usually serving — Focused Outreach has a caseload of about 300 individuals at any one time, so we're a very large program — but there are a small number of people who are admitted into jail that really needed to be psychiatrically hospitalized as opposed to incarcerated. They are obviously decompensated. They're obviously having symptoms of their mental illness, maybe responding to internal stimuli or different things, and they really don't belong in jail in the first place.

So we were able to meet with the misdemeanor court judge, and that judge agreed to develop this administrative order and give it to our program. That gives our staff person authority to have a person released from jail without having to appear before the judge and get the judge's signature. So as long as we catch that person before they're booked into the jail, we can turn around and have them released.

Lynn Aronson

Thank you, Kelly. How about Paul and John?

John Fallon

I think it's important to realize that there are different levels: law, policy, and administrative, and then on the streets, and at the direct service level of the jail. In Chicago we had criminal justice consensus groups of judges, and public defenders, and State attorneys, and Cermack Health Services, and Cook County Hospital and, Cook County Jail, and the sheriff.

All of those folks met in the Office of Mental Health. The Office of Mental Health had money at the beginning that they introduced into the system that helped focus the group. Money has that way of doing that. They worked together to establish these rules.

In addition to that, we were able to establish certain agreements at the Office of Mental Health and Cook County Jail, as a result of a law change, where they could share information and establish memorandums of understanding or continuity-of-care agreements to be able to share information. So they're able to share and notify all the agencies in Chicago who are part of a larger data project when their clients are in jail. That's a new exciting thing.

Again, the amount of people that you have to convince to be able to do anything within all these interrelated systems is terribly complicated. You just need to know that anyone who wants to become involved has to be in it for the long haul at the level of policy, and law, and administration. If it's just between you and another person, that only changes it for a short while.

You can show the advantages with an agreement among a couple of persons, but then you need to go up higher and institutionalize that. I think that's important, and we have done that, and there's a lot of people at Cermack Health Services and all these various places who have helped to do that. Dr. Lamo is certainly a champion of this for the past 20 years.

Lynn Aronson

Thank you. At this time there are no questions. So I'm going to thank our featured presenters, Hank Steadman; John Fallon; Paul Mireles; and Kelly Williams; and also Margaret Lassiter and our colleagues at Policy Research Associates, who helped enormously on the Internet access to the presentation.

Please visit the PATH Web site at www.pathprogram.samhsa.gov for other resources. Please watch for announcement of our April teleconference, which will be sent out on the PATH listserve.

Thank you all very much for participating. Good afternoon.